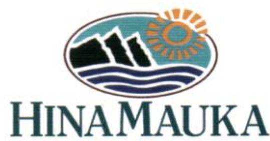


Consent to Release/Obtain Confidential Information

I, ____, authorize
(Print name of client)

Hina Mauka ______________ to disclose to ____
(Referring agency/Individual/Family)

To communicate with and disclose the following information: *(nature and amount of information as limited as possible)*
[Client to initial each category that applies]

Initial below
_____ My name and other identifying information (e.g., DOB, client #, and address)

_____ Attendance (to include dates)

_____ Discharge plan (to include discharge date and transfers)

_____ Discharge summary (to include discharge status)

_____ Appointments (to include medical, legal, and vocational)

_____ Other Progress status in treatment

_____ Other (state reason): ____

_____ Other (state reason): ____

The purpose of the disclosures authorized in this consent is for: **Consultation on behalf of the client's progress in treatment and communicate with designated representatives on the client's behalf.**
I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been in reliance on it, and that in any event this consent expires automatically as follows:

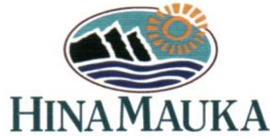
1 year from discharge date
(Specification of the date, event, or condition upon which this consent expires)

Dated:__________________ ________________________________
(Signature of client)

PROHIBITION ON RE-DISCLOSUREOF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client Name:____________________
Date: ____________________



Consent to Release/Obtain Confidential Information

I, ____, authorize
(Print name of client)

Hina Mauka_______________ to obtain from______________________________________
(Referring agency/Individual/Family)

To communicate with and obtain the following information:

[Client to initial each category that applies]

Initial below
_____ My name and other identifying information (e.g., DOB, client #, and address)

_____ Attendance (to include dates)

_____ Discharge plan (to include discharge date and transfers)

_____ Discharge summary (to include discharge status)

_____ Appointments (to include medical, legal, and vocational)

_____ Other Progress status in treatment

_____ Other (state reason): ____

_____ Other (state reason): ____

The purpose of the disclosures authorized in this consent is for: **Consultation on behalf of the clients' progress in treatment and communicate with designated representatives on the client's behalf.**
I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been in reliance on it, and that in any event this consent expires automatically as follows:

1 year from discharge date
(Specification of the date, event, or condition upon which this consent expires)

Dated:__________________ ________________________________
(Signature of client)

PROHIBITION ON RE-DISCLOSUREOF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client Name:
Date: ____________________

Client Name:____________________

Date: ___________________